STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001143	A. BUILDING _____ B. WING _____	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA ENDOSCOPY CENTERS	1115 N RONALD REAGAN PKWY STE 347 AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 000	INITIAL COMMENTS This visit was for a re-certification survey. Facility Number: 003796 Survey Date: 10-05/08-2015 QA: JL 10/28/15	Q 000		
Q 245	416.51(b)(3) INFECTION CONTROL PROGRAM The program is - Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. This STANDARD is not met as evidenced by: Based on document review and interview, the infection control committee failed to provide corrective action plans for surveillance, implementing corrective and preventive measures, and assuring resolution of identified problems according to its Infection Prevention/Control Plan in 2 instances. Findings: 1. Review of policy 1.07B, titled Infection Control Plan, revised/reapproved 7/22/14, indicated results of infection control monitoring shall be reported and reviewed by the Infection Control Committee, Quality Assurance Committee, Board of Managers, and professional staff on a quarterly basis or more often as needed.	Q 245		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 245	Continued From page 1 2. Review of Quarterly Infection Prevention/Control Meeting minutes for 9/29/14, indicated employee P11 (Infection Control Nurse/Staff Nurse), and employee P1 (Infection Preventionist) are working on a 10 step for HH (hand hygiene). Further review of the meeting minutes indicated the facility will complete a performance improvement study related to scope reprocessing. 3. Review of Quarterly Infection Prevention/Control Meeting minutes dated 10/30/14, 1/30/15, and 6/30/15, indicated there was no documentation of any data collected or actions taken regarding hand hygiene and scope reprocessing. 4. In interview, on 10/6/15 at approximately 1515 hours, employee P1 confirmed there was no documentation at the above-mentioned Infection Prevention/Control meetings of 10/30/14, 1/30/15, and 6/30/15, and no other documentation was provided prior to exit.	Q 245		